

First Presbyterian Church

Elementary and Nursery/Preschool

Consent for Administering Medication, Emergency Treatment, Diagnostic Testing and/or Admission to Hospital/Medical Facility

Permission

I, _____, hereby consent for _____
(Parent/Legal Guardian) (Leader or Organization name)

to administer necessary medication and to give permission regarding emergency treatment, diagnostic testing, and/or admission to a hospital or medical facility, including procedures performed by physicians, employees of the hospital and/or health care professionals for:

_____ while in the care of First Presbyterian Church staff or designated
(Name of child or children)
leaders.

I acknowledge that no warranty or guarantee have been made to me as to the effect of such examinations or treatment on the child's condition. I acknowledge that I am financially responsible for all charges in connection with care and treatment rendered to:

(Name of child or children)

Signature: _____ Date _____
(Parent/Legal Guardian)

State of _____

County of _____

Notary is Required

Why? If your child needs medical attention a hospital/medical facility will require that this form be notarized before administering treatment.

Taken, subscribed and sworn before me, a notary public in said county,

this _____ day of _____ 20____.

My Commission expires _____

Signature _____

Important Information for Treatment

Father's Full Name _____ Cell Phone _____

Mother's Full Name _____ Cell Phone _____

Other Guardian Name _____ Cell Phone _____

Home Phone _____ Home Address _____

City _____ State _____ Zip Code _____

Medical information for Participant(s)

Child's Full Name _____

List specific medical needs/ conditions _____

List all allergies _____

List all medications _____

Date of last tetanus _____ Are immunizations up to date? _____

Participant 2

Child's Full Name _____

List specific medical needs/ conditions _____

List all allergies _____

List all medications _____

Date of last tetanus _____ Are immunizations up to date? _____

Attach a Copy of a Medical Insurance Card

Emergency Contact Person _____

Phone Number _____ Relationship to child _____

Family Physician _____ Telephone Number _____